C-07-6479-TEH (PR)

EXHIBIT "A"

Supplement to motion for Counsel

Case NO.: CV-07-6479

of the top of the acetabulum. There was no femoral neck remaining above the lesser trochanter. The acetabulum was cleared of dense scar tissue that had filled in. The sciatic nerve was traced up with blunt dissection into the greater sciatic notch and bleeding was noted at that point, but no single vessel was identified. Dr. Bilello came in, we packed the area with lap packs, used Gelfoam soaked in thrombin and gained control of some peripheral bleeding in the maximus and medius muscles and eventually the bleeding from the sciatic notch which might have been a superior gluteal vessel ceased to well up. The femur was prepared initially using a cooker cutter to penetrate the dense cortical cap which had sealed the femoral neck. Using a ball tipped guide wire over which cannulated flexible reamers and cannulated ridge reamers were passed. The trochanteric fossa was cleared of bone and soft tissue with a rongeur and the cookie cutter and a Ben Hur instrument. The final flexible and rigid reamer used was size 15.5 mm and conical reamers for the 20 B and D sleeves were used followed the triangle Miller frame assembly so that a drill bit could prepare a little room for the triangle. There was actually no bone above the lesser trochanter so this only shaved some bone off of the calcar region from the lesser trochanter down. A trial implant insertion using a 20D small sleeve and the 20 x 15, 36+8 lat anteverted bowed coronally-slotted stem tipped SROM femoral component (left) was noted to fit well. The acetabulum was exposed with retractors and reaming from 47 mm to 57 mm was performed at an orientation of 45 degrees abduction and 15 degrees of anteversion. Reaming was deepened until the medial wall was paper thin as an intentional strategy to provide posterior wall coverage from column bone as the patient had a deficiency of the posterior wall from whatever injury he had, had in the past. A 58 mm DePuy solution/Pinnacle revision shell with peripheral end dome screws was used. Three excellent peripheral screws; one excellent dome screw and one good dome screw were inserted. The 32 mm Marathon poly liner +4 lateralizing with 10 degree lip positioned at 2:30 on the clockface was impacted into the shell after inserting an apical screw hole cover. The femoral components which had been sized with the trials were then implanted. A +9, 32 mm femoral head was impacted onto the clean dry trunnion after trialing a 0, +6 and +12. The +9 provided excellent soft tissue tension stability and there was no impingement. Range of motion was excellent. The wound was thoroughly irrigated. The one last loose screw was not within the field of dissection and therefore left there. The gluteus maximus tendon insertion, short external rotators, posterior capsule and fascia lata were all repaired with 1-0 Vicryl. The sciatica nerve was noted to be fully intact prior to closing the fascia. The short external rotator capsule layer interposed between the nerve and the acetabular component. The posterior edge of the acetabular component, was anticipated, was not fully covered by bone but there was a good 85% of the component covered. The subcutaneous tissue was closed with 0 Vicryl, dermis with 2-0 Vicryl and the skin with staples. A medium Hemovac drain was left deep to fascia, exiting through a stab anterior to the incision. Final x-rays were obtained prior to leaving the operating room showing that the component was well positioned, sized and reduced.

Sterile dressings were applied. The patient was turned supine and abduction pillow was placed between his legs and he was taken to the recovery room having tolerated the procedure well.

Abraham Appleton, MD

cc: Abraham Appleton, MD
Arturo R Avila, PA
John F. Bilello, MD

AA:mdq/000163988
D: 04/01/2004 1:00 P
T: 04/02/2004 8:10 A
Doc#:1248111 CVP 4/6.

1 CORCORAN DISTRICT HOSPITAL

NAME:	VELASQUEZ, K. T-73607	PT #:	51809036
DR:	D. SMITH	MR #:	036761
		DATE OF OPERATION:	04/03/03
DD:	04/03/03	DT:	04/04/03

cc: SATF

REPORT OF OPERATION/PROCEDURE

PREOPERATIVE DIAGNOSIS: Painful interlocking screws, right distal tibia.

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION: Removal of screws, right distal tibia.

SURGEON: David G. Smith, M.D.

ANESTHESIA: General.

PROCEDURE: The patient was brought to the operating room. Satisfactory anesthesia was established. The right leg was sterilely prepped with betadine solution and draped in the usual fashion. The pneumatic tourniquet was utilized at 300 mm of mercury and 0.50% Marcaine with epinephrine was instilled into the incision sites over the two distal screws which were easily palpable on the medial aspect of the distal tibia. Incisions were carried down to the screws and the screws were removed without difficulty. There was no evidence of infection. Bleeding points were coagulated with the Bovie cautery. The tourniquet was deflated. The wound was irrigated. Closure was carried out with interrupted 3-0 nylon suture. Betadine ointment, Adaptic and sterile dressings were applied followed by an Ace wrap. He was transferred to the recovery room in satisfactory condition. There were no complications. He tolerated the procedure well.

DGS/ph

DAVID G. SMITH, M.D.

UNIVERSITY MEDICAL CENTER 445 SOUTH CEDAR, FRESNO, CA 93702

PATIENT NAME: VELASQUEZ, Kim
MED REC #: 01457817
DOB: 21May1960
PATIENT TYPE: O
LOCATION: ORO
EXAM DATE: 29Sep2003
ACCOUNT #: 107883082
ACCESSION #: 4658469

ORDER DOCTOR: NAENI, FARIBORZ
ADDRESS: 445 S. Cedar
Fresno CA 93702

XRAY-FEMUR 2 VIEWS LEFT

LEFT FEMUR 09/29/2003

HISTORY:

Pain.

FINDINGS:

Multiple views of the left femur again demonstrate the absence of the femoral head and neck. There is a screw within the soft tissue of the proximal thigh. There is disuse osteopenia. The knee insofar as seen appears small.

IMPRESSION: **Absent femoral head and neck. No acute process.**

EJ
10/02/03
FRED A. LOGALBO, MD

FRED A. LOGALBO, MD

TRANSCRIPTION REPORT MRN#: 01457817

DEPARTMENT OF MEDICAL RECORDS

Admit: 04/01/2004 VELASQUEZ, Kim

01457817/109097826

05/21/1960

Location: 4WS 40302

43 M

OPERATIVE REPORT:

DATE OF SURGERY:
4/1/04

PREOPERATIVE DIAGNOSIS:
Post traumatic arthritis of the left hip (absent femoral head ?, status post Girdlestone procedure or failed open reduction internal fixation of acetabular fracture with femoral head erosion?) Loose hardware from the acetabulum. Acetabular bone defect, limb length discrepancy.

PROCEDURE:
Left total hip replacement and removal of loose screws.

SURGEON:
Abraham Appleton, MD

ASSISTANT:
Arturo Avila, PA
John Bilello, MD

ANESTHESIA:
General.

ESTIMATED BLOOD LOSS:
2500 cc. There were 8 units packed red blood cells transfused, platelet transfusions were initiated prior to leaving the operating room. One Hemovac drain was used.

COMPLICATIONS:
None.

SUMMARY OF THE PROCEDURE:
The patient was taken to the OR, placed supine on the table, general anesthesia was induced and he was endotracheally intubated. A Foley catheter was inserted. He was turned to the right lateral decubitus position and secured in place with the Universal lateral hip positioner. His left lower extremity was elevated, scrubbed, prepped and sterilely draped free. His old posterior approach incisional scar was reincised. The skin flaps were kept thick, dissection was taken through subcutaneous tissue. The fascia lata, gluteus maximus tendon insertion was divided. The sciatic nerve was identified and protected throughout the procedure. Short external rotators and posterior capsule were divided. The hip had shortened with loss of the femoral head so that the greater trochanter was above the level

GENERAL INSTRUCTIONS FOR HEPATITIS C PATIENTS

- AVOID USE OF ALCOHOL
- DO NOT USE INJECTION DRUGS
- DO NOT "SNORT" DRUGS
- DO NOT GET ANY ILLEGAL TATTOOS
- DO NOT SHARE YOUR TOOTHBRUSH, RAZOR, OR OTHER PERSONAL CARE ITEMS
- REDUCE WEIGHT IF OVERWEIGHT
- EAT A WELL-BALANCED HEART HEALTHY DIET
- DRINK PLENTY OF FLUIDS
- GET ADEQUATE REST AND REGULAR EXERCISE
- STOP SMOKING
- *ASPIRIN* AND *IBUPROFEN (MOTRIN, ADVIL)* SHOULD BE USED WITH EXTREME CAUTION AND ONLY AFTER DISCUSSION WITH YOUR PHYSICIAN
- YOU MAY USE *ACETAMINOPHEN (TYLENOL)* FOR PAIN OR OTHER *ACETAMINOPHEN* CONTAINING MEDICATIONS, BUT THE DOSE SHOULD NOT EXCEED 4 GRAMS PER DAY. CHRONIC USE SHOULD BE AVOIDED
- AVOID TAKING SUPPLEMENTAL IRON
- DO NOT DONATE BLOOD, TISSUE, OR ORGANS
- MINIMIZE USE OF PAIN MEDICATIONS, ESPECIALLY NARCOTICS

Attachment A

California Department of Corrections Hepatitis C Clinical Management Program

HEPATITIS C
PATIENT INFORMATION

WHAT IS HEPATITIS C?

Hepatitis is any inflammation of the liver. The most common causes of liver inflammation are viruses, drugs, and alcohol. *Hepatitis C* is one of the viruses which may cause liver inflammation or hepatitis.

HOW IS IT SPREAD?

Hepatitis is most commonly acquired from contaminated needles (including tattooing needles), snorting drugs, using shared paraphernalia, or from a blood transfusion prior to 1990. Other risk factors for hepatitis C include hemodialysis or job exposure to human blood. At the present time, there is no vaccine to prevent hepatitis C infection.

DIAGNOSIS

Most people with the infection look and feel well and they have usually had the virus for many years before the diagnosis. The infection is usually diagnosed when abnormalities are found on a routine blood test or at the time of blood donation.

After acquiring the hepatitis C virus, the infected individual makes antibodies against the virus (Hepatitis C virus antibodies). These antibodies are detected during screening for hepatitis C. Although disease-specific antibodies usually signify immunity from the disease they attack, in the case of hepatitis C, the antibodies are <u>not</u> protective and having antibodies does not mean the infection has resolved or that the patient is immune. The vast majority of those with hepatitis C virus *antibodies* also carry the virus.

If you have antibody to hepatitis C, you will have a blood test to determine if the hepatitis C virus is present. If you test positive for the virus, you have hepatitis C infection.

After the hepatitis C virus is detected, another important test to perform is the viral genotype. Genotypes are subgroups of the virus sharing genetic properties. The various genotypes of hepatitis C have different behaviors and respond differently to treatment. Hepatitis C genotypes 1, 2, 3, and 4, are the most common. Genotypes 2 and 3 are the most responsive to treatment.

WHAT DOES THE HEPATITIS C VIRUS DO?

You cannot live without your liver. It removes drugs from your system and it produces many essential products, including cholesterol, proteins, and clotting factors. The hepatitis C virus inhabits liver cells and causes inflammation. Over time, this ongoing inflammation injures the structure and function of the liver cells. In most persons, this is typically a very slow process. Only some (10 to 20 percent) of persons with hepatitis C go on to develop serious liver injury, and in those persons, it takes many years (10 to 40). Alcohol use will cause any person with hepatitis C to develop more rapid and severe liver injury. In those persons with advanced hepatitis C disease, severe liver scarring (cirrhosis), and even liver cancer (hepatocellular carcinoma) or failure may occur.

SYMPTOMS

Most people carrying the virus feel well. In those persons in whom the disease progresses, symptoms generally are minimal until the disease is quite advanced. The severity of the disease can be assessed by history and examination, laboratory markers and, most reliably, by liver biopsy. End stage liver disease may result in abdominal swelling (ascites); mental confusion (encephalopathy); bleeding from the esophagus or stomach due to varices (enlarged veins); liver cancer; or other serious complications.

TREATMENT

If repeated blood tests show the liver is functioning differently than normal, a liver biopsy may be performed. This test is done in a clinical setting, and the patient generally does not stay for more than a few hours to be observed after the biopsy is completed. It requires using a special needle to pierce the skin and obtain a small piece of the liver for microscopic examination, to determine the degree of liver damage. This is one of the most important factors in deciding whether drug treatment for the hepatitis C virus might be offered.

At present, there are only a few drugs available to treat hepatitis C. The course of therapy is long and must be uninterrupted to get the maximum chance for cure. It is typically associated with some unpleasant side effects, although many can be managed with physician monitoring and medication adjustments. With this therapy, about 50 to 60 percent of patients clear the infection and are considered cured. However, a person can still be re-infected if re-exposed to hepatitis C. There is no evidence that treatment administered at the last stages of HCV significantly reduces the effectiveness of the drug treatment. Currently there is no medical evidence that shows that treatment or lack of treatment significantly impacts the risk of complications related to severe liver disease.

EXHIBIT 1

The Patient was given the following documents on Dec 3, 2007

LIVER DISEASE DIET - General Information, English

Liver Disease Diet

GENERAL INFORMATION:

What is a liver disease diet?

- The liver is an organ in the body that does several important tasks. One task of the liver is to help the body use the nutrients in food for energy. Liver diseases such as hepatitis and cirrhosis may change the way your body uses nutrients from food. Nutrients include carbohydrate (kahr-boh-HEYE-drayt), protein, fat, vitamins and minerals. Some people with liver disease may not get enough nutrients and lose weight because of these changes.

- A liver disease diet provides the right amount of calories, nutrients, and liquids for you. A liver disease diet may help your liver work better and prevent other health problems. The dietary changes you will need to make depend on the type of liver disease and health problems you have. Your dietitian (di-uh-TISH-in) or nutritionist (noo-TRI-shun-ist) will tell you about the type of diet that is best for you.

What can I do to make a liver disease diet part of my lifestyle?Changing what you eat and drink may be hard at first. You may need to make these changes part of your daily routine. Following a liver disease diet may help you feel better.

- Choose a variety of items on this diet to avoid getting tired of having the same items every day. Keep a list of items allowed on this diet in your kitchen to remind you about the diet.

- Carry a list of items allowed on this diet to remind you about the diet when you are away from home. Tell your family or friends about this diet so that they can remind you about the diet.

- Ask your caregiver, a dietitian, or a nutritionist any questions you may have about your diet plan. A dietitian or nutritionist works with you to find the right diet plan for you. These caregivers can also help to make your new diet a regular part of your life.

What should I avoid eating and drinking while on a liver disease diet?The foods that you need to avoid or limit depend on the type of liver disease and health problems you have. Following are some of the dietary changes that you may need to make:

- **Sodium:** You may need to decrease the amount of sodium in your diet. Sodium causes your body to retain (hold on to) fluids. When your body holds on to fluids, you will have swelling. Your caregiver may suggest that you limit or avoid high-sodium foods. Your caregiver will give you more information about a low-sodium diet. Some foods that contain high amounts of sodium are the following:
    - Bacon, sausage and deli meats.
    - Canned vegetables and vegetable juice.
    - Frozen dinners.

- Packaged snack foods like potato chips and pretzels.
- Soy, barbecue, and teriyaki sauces.
- Soups.
- Table salt.

- **Liquids:** You may also have to drink fewer liquids if you have swelling. Liquids include water, milk, juice, soda, and other beverages. It also includes any food that contains liquid, such as soup. This also includes food that melts when it is not cold, such as gelatin. Talk to your caregiver about the amount of liquid you may drink each day.
- **Alcohol:** Alcohol may make your liver disease worse. Avoid alcoholic drinks such as beer, wine, hard liquor (whiskey, gin, vodka) or mixed drinks (drinks made with hard liquor). Talk to your caregiver if you have questions about alcohol in your diet.

What can I eat while on a liver disease diet?

- **Eat _____ grams of protein each day.**
- **Eat _____ grams of sodium each day.**
- **Drink _____ ounces of liquid each day.**
- **Calories:** Eat a variety of foods each day to help your liver work as well as possible, and to keep a healthy weight. You may not feel hungry or you may feel full right away after eating. This may make it hard for you to eat enough calories. Eat several small meals throughout the day instead of large meals to make sure you eat enough calories. Ask your dietitian or nutritionist how many calories you need each day.
- **Protein:** It is important to eat the right amount of protein when you have liver disease. Your dietitian or nutritionist will tell you how much protein you should have each day. The following foods are good sources of protein. The amount of protein (in grams) follows each listed food.
  - Three ounces of meat, poultry (chicken), or fish (21 grams).
  - One cup of milk or yogurt (eight grams).
  - One large egg (seven grams).
  - Two tablespoons of peanut butter (seven grams).
  - One-half of a cup of tofu (seven grams).
  - One-fourth of a cup of cottage cheese (seven grams).
  - One ounce of cheese (seven grams).
  - One-half of a cup of cooked, dried, pinto, kidney or navy beans (three grams).

- **Fat:** Your caregiver will tell you how much fat you should have in your diet each day. Some people with liver disease have problems with digesting (breaking down) and absorbing (using) fat. The fat that is not broken down and used by the body is lost in bowel movements. If you have this health problem, you may need to eat less fat. Your doctor may also suggest that you eat a special type of fat that is absorbed more easily by your body.

- **Carbohydrates:** Your caregiver will tell you how much carbohydrate you should eat each day. Carbohydrates are found in breads, cereals, grains (rice, oats), starchy vegetables (potatoes, corn, peas), and crackers. Liver disease may cause blood sugar levels to be too high or too low in some people. You may need to make changes in your diet if you have this problem. Eating certain amounts of carbohydrates at each meal helps to control blood sugar levels.

What other diet guidelines should I follow?

- Talk to your caregiver before taking any vitamins or herbal supplements (pills).

- Talk to your dietitian or nutritionist about any other diet changes you should make. Liver disease may cause several different health problems. Your caregiver may suggest that you make other diet changes that can help to improve your health.

Risks:

- You may not get enough nutrients and lose weight if you do not eat a balanced diet. Not following a liver disease diet may cause certain health problems to become worse.

- Liver disease may cause you to lose your appetite and feel full too quickly after eating. This may make it hard for you to eat enough calories. Talk to your caregiver if you are having trouble eating and drinking.

CARE AGREEMENT:

You have the right to help plan your care. To help with this plan, you must learn about your diet. You can then discuss treatment options with your caregivers. Work with them to decide what care may be used to treat you. You always have the right to refuse treatment.

LIVER DISEASE DIET - General Information, English
Printed on Monday, December 3, 2007 6:35:31 AM

804 TO RECORDS ON _____ BY _____

STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS

RULES VIOLATION REPORT

CDC NUMBER	INMATE'S NAME	RELEASE/BOARD DATE	INST.	HOUSING NO.	LOG NO.
T-73607	VELASQUEZ	[illegible]	CSMTF/SP	FEE2T1-153L	[illegible]

VIOLATED RULE NO(S).	SPECIFIC ACTS	LOCATION	DATE	TIME
3041(d)	PERFORMANCE	E-EDU	12/10/07	0900

CIRCUMSTANCES

On Monday, December 10, 2007, at approximately 0900 hours, while performing my duties as Facility 'E' ABE I/II Instructor, I observed that Inmate **VELASQUEZ, T-73607, FEE2T1-153L,** failed to report to his assigned ABE I/II class on 'E' Facility. On this date, Correctional Officer Adame at 'E' Work Change informed me that Inmate **VELASQUEZ** refused to come to class. Inmate **VELASQUEZ** has failed to report to his assignment ABE%E.137 since his assignment date of 07/07/07 (DMS 07-199). Inmate **VELASQUEZ** has previously been issued a CDC 128A and a CDC 115 for this same offense while assigned to this class. Inmate **VELASQUEZ** will receive an 'A' day for each unexcused absence. I am requesting that Inmate **VELASQUEZ** be removed from education by a committee action for failure to program. Inmate **VELASQUEZ** is aware of this report. Inmate **VELASQUEZ** is **not** a participant in the Mental Health Services Delivery System at any level of care. Furthermore, Inmate **VELASQUEZ** did not display any bizarre, unusual, or uncharacteristic behavior at the time of this rules violation. Inmate **VELASQUEZ** has a TABE score **ABOVE/BELOW 4.0.**

REPORTING EMPLOYEE (Typed Name and Signature)	DATE	ASSIGNMENT	RDO'S
I. REYNA	12/11/07	ABE I/II INSTRUCTOR	[illegible]

REVIEWING SUPERVISOR'S SIGNATURE	DATE	☐ INMATE SEGREGATED PENDING HEARING
M. DERDERIAN, SERGEANT	12-11-07	DATE _____ LOC. _____

CLASSIFIED	OFFENSE DIVISION:	DATE	CLASSIFIED BY (Typed Name and Signature)	HEARING REFERRED TO
☐ ADMINISTRATIVE ☐ SERIOUS	_____		D.A. CUEVAS, FACILITY 'E' CAPTAIN	☐ HO ☐ SHO ☐ SC ☐ FC

COPIES GIVEN INMATE BEFORE HEARING

	BY: (STAFF'S SIGNATURE)	DATE	TIME	TITLE OF SUPPLEMENT		
☐ CDC 115	[illegible]	[illegible]	[illegible]	[illegible]		
☐ INCIDENT REPORT LOG NUMBER: _____	BY: (STAFF'S SIGNATURE) [illegible]	DATE	TIME	BY: (STAFF'S SIGNATURE) [illegible]	DATE	TIME

HEARING

REFERRED TO ☐ CLASSIFICATION ☐ BPT/NAEA

ACTION BY: (TYPED NAME)	SIGNATURE	DATE	TIME

REVIEWED BY: (SIGNATURE)	DATE	CHIEF DISCIPLINARY OFFICER'S SIGNATURE	DATE
D.A. CUEVAS, FACILITY 'E' CAPTAIN		D. FULKS, ASSOCIATE WARDEN	

☐ COPY OF CDC 115 GIVEN INMATE AFTER HEARING	BY: (STAFF'S SIGNATURE)	DATE	TIME

CDC 115 (7/88)

"EXHIBIT A"

19

INMATE: VELASQUEZ, KIM CDC#: T73607 HOUSING: FA-B3-170L

This inmate is PERMANENTLY MOBILITY IMPAIRED and uses a CANE to assist with ambulation (DPM). He cannot walk 100 yards or up a flight of stairs without pausing with the use of aids. REQUIRES LOWER BUNK, NO STAIRS, NO TRIPLE BUNK. THIS DISABILITY IMPACTS PLACEMENT. LIMITATIONS: No prolonged Standing/Walking 50% of the time in assignment. No REPETITIVE digging, bending, or lifting over 15 lbs. CSR ALERT: Requires relatively level terrain and no obstructions in path of travel.

CC Health Record
C-File
Inmate Assignment
CCI/CCII
Housing Officer
Inmate

COPY

Signature: O. Beregovskaya, M.D.

Arrival Date: 9/26/2006

Date: 03/05/07 HEALTH SERVICES CHRONO SATF CDC-128-C

INMATE: VELASQUEZ, KIM CDC#: T73607 HOUSING: FA-B3-170L

This inmate has a PERMANENT MEDICAL CONDITION: NO PROLONGED SITTING: More than 70% of the time on an assignment. For classroom setting, allowing standing breaks at instructor's discretion.

CC Health Record
C-File
Inmate Assignment
CCI/CCII
Housing Officer
Inmate

COPY

Signature: O. Beregovskaya, M.D.

Arrival Date: 9/26/2006

Date: 03/05/07 HEALTH SERVICES CHRONO SATF CDC-128-C

INMATE: VELASQUEZ, KIM CDC#: T73607 HOUSING: FA-B3-170L

REMOVAL FROM A DPP CODE: Removal from previous DPP code(s): "DNM" PHYSICIAN'S COMMENTS: Progressive orthopedic condition. Status change from DNM to DPM

CC Health Record
C-File
Inmate Assignment
CCI/CCII
Housing Officer
Inmate

COPY

Signature: O. Beregovskaya, M.D.

Arrival Date: 9/26/2006

Date: 03/05/07 HEALTH SERVICES CHRONO SATF CDC-128-C

STATE OF CALIFORNIA
CDC 7393 (11/02)

NOTIFICATION OF DIAGNOSTIC TEST RESULTS

NAME	CDC NUMBER
Velasquez	T73607
INSTITUTION	HOUSING
CSATF	A3 1702
TYPE OF TEST	DATE OF TEST
X-Ray	1/4/07

YOUR TEST RESULTS HAVE BEEN EVALUATED BY A PHYSICIAN AND THE FOLLOWING HAS BEEN DETERMINED:

- ☐ Your test results are essentially within normal limits or are unchanged and no physician follow up is required.
- ☒ You are being scheduled for a follow up medical appointment. You will be receiving a ducat indicating your appointment time.
- ☐ A repeat test will be ordered. You will be ducated for this test.
- ☒ A chronic care appointment has been scheduled for you. You will be receiving a ducat indicating your appointment time.

O Blachet

NAME / TITLE

PHYSICIAN SIGNATURE

1/16/07

DATE

ORIGINAL - File in UHR CANARY - Scheduler PINK - Patient

25

EXHIBIT B

26

KERN RADIOLOGY MEDICAL GROUP, INC.
2301 Bahamas Drive
Bakersfield, CA 93309
(661) 326-9600

CORCORAN STATE PRISON (C.S.A.T.F.)
FAX: (559) 992-7104

PATIENT: VELASQUEZ DOB: CDC#: T73667
HOUSING #:

INTERPRETATION OF OUTSIDE FILMS: RIGHT FOREARM: 01/04/07

There is a nonunion fracture in the proximal shaft of the radius. The ends of the fracture appear to be well healed and there is a pseudoarthrosis at the fracture site. Elbow joint and wrist joint are grossly intact.

IMPRESSION:

Nonunion fracture in the proximal shaft of the right radius with pseudoarthrosis.

HL

Howard E. Leventhal, M.D. D: 01/05/2007 T: 01/08/2007/lmj

Referring Physician: BEREGOVSKAYA

EXHIBIT D

27

KERN RADIOLOGY MEDICAL GROUP, INC.
2301 Bahamas Drive
Bakersfield, CA 93309
(661) 326-9600

CORCORAN STATE PRISON (C.S.A.T.F.)
FAX: (559) 992-7104

PATIENT: VELASQUEZ DOB: CDC#: T73607
HOUSING #:

INTERPRETATION OF OUTSIDE FILMS: PELVIS AND BILATERAL HIPS: 11/29/06

There is a left hip prosthesis, which is mostly in anatomic position, although the acetabulum has been remodeled, either surgically or through repetitive stress with slight protrusio and cephalic displacement of the acetabulum. There are multiple acetabular screws embedded in the iliac bone. There is a screw in the proximal soft tissues of the left thigh, which is detached and free-floating within the soft tissues. The visualized femoral stem is otherwise anatomic in position. The right hip is normal in appearance. The bowel gas pattern is nonspecific.

IMPRESSION:

Left hip replacement in position as described with some remodeling of the acetabulum and a free-floating screw in the soft tissues of the proximal thigh medially.

Jeffrey K. Child, M.D. D: 11/30/2006 T: 12/01/2006/lmj

Referring Physician: BEREGOVSKAYA

CA3 1101L

EXHIBIT B

patient	VELASQUEZ, Kim
CDC #	T73607
date/birth	05/21/60
date	05/07/07
physician	Surya

Procedure: *X-ray of the Bilateral Hips [two views]*

Indication: Status post left total hip replacement.

Protocol: The AP neutral and frogleg views of the bilateral hips are presented.

Findings: Deformity of the left inferior pubic ramus and the ischium, consistent with old healed fracture, is noted. Postsurgical changes from left hip arthroplasty are noted. Left protrusio acetabuli is present. Migration of the acetabular portion of the prosthesis in the cranial direction is visualized. A screw without attachment to osseous structures is visible medial to the proximal femur. A probable old right rib fracture is noted.

Impression:

1. Old fractures.
2. Left protrusio acetabuli.
3. Cranial migration of the acetabular component of the left hip prosthesis.
4. A fixation screw without attachment to an osseous structure, located medial to the proximal left femur.

Thank you for the opportunity to assist you with the care of your patient.

M. Deguchi

Mario Deguchi, MD, DMD, MSE
Diplomate of the American Board of Radiology

MD:jjz

dd: 05/09/07
dt: 05/0907

electronically authenticated by Mario Deguchi, MD, DMD, MSE